Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING
AND
TREATMENT PROGRAM POLICY

EXHIBITS

01/ 07/ 2009

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EXHIBIT A

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
EMPLOYEE NOTICE OF POLICY, CONSENT AND RELEASE

Your Employer is a member of the Sheet Metal Workers Local Union #33 Substance Abuse Testing and Treatment Program (Program). The Program prohibits the use, abuse, presence in the body, or reporting to work under the influence, bringing onto the worksite, the unlawful manufacture, distribution, possession, transfer, storage, concealment, transportation, promotion or sale of illegal and unauthorized drugs, controlled substances, alcoholic beverages or drug related paraphernalia by employees. Any of the forgoing is a violation of the Program and will subject the employee to disciplinary action, up to and including immediate termination.

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The following types of testing will be conducted under the Program by use of urine, breath, saliva or blood:

Implementation Testing	**Pre-employment Testing**	**Pre-Access Testing**
Random Testing	**Post-Accident/Incident Testing**	**Return-to-Work Testing**
Reasonable Suspicion/Cause Testing	**Follow-up/Probationary Status Testing**	

I understand that my refusal to submit to an alcohol or drug test, or my refusal to cooperate fully with the drug testing procedures, a positive test result, or any violation of the Program, will be sufficient cause for disciplinary action, up to and including immediate termination. Any and all discipline provided hereunder against union-represented bargaining unit employees shall be subject to the grievance/arbitration provision of the parties' applicable collective bargaining agreement.

My signature below acknowledges that a copy of the Substance Abuse Testing and Assistance Program Policy has been provided to me, I have read and understand this document and agree to comply with the Program.

I consent to have trained personnel collect urine, breath, saliva or blood samples from me to determine the presence or use of illegal drugs or controlled substances and alcohol in connection with my employment or future employment.

I authorize the release of my test results to my current employer for employment purposes, my employer's Third-Party Administrator (TPA), the clinic, the laboratory, and the Medical Review Officer (MRO). I also authorize the release of my test results as legally required and upon request to the parties of a grievance initiated by the employee or union.

In addition, to facilitate and expedite future employment or referral opportunities, I authorize Construction Data Services (CDS) to add my name and related eligibility status to the Program database and/or other United Association approved databases to permit customers of my employer and other contractor companies that could be my future employers to view my eligibility status in connection with my potential employment.

I authorize the MRO to verify my health information as it pertains to my drug test results with my prescribing physician and issuing pharmacist.

In the event the drug test results are positive, I acknowledge that I have the right to request that the **original sample** be retested by a SAMHSA certified laboratory of my choice. This request must be postmarked within two (2) days of the date of being notified of the confirmed positive test result. I agree to pay the initial cost for a retest in advance to the MRO. In the event that said retest should prove to be negative, I will be reimbursed for the cost of the test, paid any back wages and benefits lost, and made re-eligible for hire if work is available or reinstated as an employee provided work is available on the Employer's property. I acknowledge that in instances where a replacement employee has been utilized by the Employer during the interim period (i.e., from the time when I was taken off the job because of the preliminary positive test to the time that confirmation of the test was deemed negative), and the rehiring of me to replace said replacement employee shall cause a hardship, the Employer is not required to immediately rehire me in the same position I held at the time of submitting to the drug and alcohol testing procedure.

Employee **SIGNATURE**	Employee ID Number (Union Book #)	Craft / Local#
Employee **PRINTED** name	Employer	Date

5-22-08

Please fax completed form to: 314-645-6767 or 866-645-6767

Exhibit B

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
EMPLOYER/UNION REGISTRATION

Employer/Union Legal Name _____

Street Address _____
NO PO BOX

City _____ State _____ Zip _____

Phone Number ( ) _____ Fax ( ) _____

E-mail Address: _____

COMMUNICATORS

Please designate one (1) Primary and at least one (1) Alternate communicator. Your communicators will be the only persons from within your organization that will be able to request, receive and/or discuss test result information.
I hereby authorize ☐ remove ☐ the following communicators:

The following person is designated as our **PRIMARY** communicator:

_____

The following person is designated as our **ALTERNATE** communicator:

_____

This agreement by and between CONSTRUCTION DATA SERVICES (CDS) and the above listed COMPANY consists of the following understandings and conditions: COMPANY designates CDS to act as its agent as it applies to the services provided by CDS. COMPANY understands that information is to be requested or accessed only by its designated personnel (COMMUNICATORS), and solely for business purposes falling within the scope of their official duties. COMPANY has instructed each of its Communicators that all testing information is to be kept completely confidential and to be used solely for business purposes.

COMPANY agrees to pay CDS for each test or other service ordered from CDS, in accordance with CDS' Drug and Alcohol Test Fee Schedule. CDS will bill weekly for all tests performed during the prior week. COMPANY agrees to pay all invoices within thirty (30) days after the invoice date, without regard to reimbursement from any fund. For any invoice not paid within thirty (30) days of the invoice date, CDS will add, and COMPANY agrees to pay, a SERVICE CHARGE of 1 ½ % per month. COMPANY agrees to pay CDS' reasonable attorney's fees and costs incurred in the collection of any unpaid invoices, and consents to suit in state court in St. Louis, MO. CDS reserves the right to suspend or terminate services to COMPANY should any invoice remain unpaid for more than 45 days.

_____	_____	_____
Signature of Company Official	**Title**	**Date**

For CDS use only

Received _____ Client # _____

Please Fax To: 314-645-6767 or 866-645-6767

Exhibit C

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
COMMUNICATOR AUTHORIZATION AND SETUP

EACH COMMUNICATOR MUST SUBMIT A SEPARATE COPY OF THIS FORM

A COMPANY OFFICER MUST DESIGNATE THE PRIMARY AND ALTERNATE COMMUNICATORS FOR YOUR COMPANY. YOUR COMMUNICATORS WILL ACT AS THE SOLE CONTACT PERSONS FROM WITHIN YOUR COMPANY AND WILL BE RESPONSIBLE FOR THE ADMINISTRATION OF THE PROGRAM AND THE RECEIVING OF NON-NEGATIVE AND POSITIVE TEST RESULTS. COMMUNICATORS DESIGNATED BY THE COMPANY OFFICER UNDERSTAND THAT ALL TEST RESULTS MUST BE KEPT CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.

COMPANY OFFICER: I authorize the below listed employees to act as our communicators:

Signature of company officer _____ Title _____

Company Name _____

Signature of Communicator _____ Date _____

INSTRUCTIONS FOR THE COMPLETION OF THIS FORM:
Each communicator must submit a separate copy of this form signed by a company officer indicating their individual password in the appropriate space. Your password can be up to ten (10) letters in length. Please select your password carefully, as it will be requested from you as a means of identification. CDS will assign your access number and notify you of such.

NO INFORMATION WILL BE RELEASED WITHOUT A VALID ACCESS NUMBER AND PASSWORD

The following person is to be our **PRIMARY** ☐ **ALTERNATE** ☐ communicator:

Name _____ Title _____

Cell Phone Number _____ Beeper # _____

E-mail Address _____

Password _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

CDS will mail you a confirmation letter with your PASSWORD and assigned ACCESS NUMBER. No information will be released to you by our office without furnishing us with this ACCESS NUMBER and PASSWORD.

PLEASE FAX TO:
314-645-6767 or 866-645-6767

Exhibit D

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
SUBSTANCE ABUSE TESTING NOTIFICATION

Date _____ **Employer** _____ **Submitted by:** _____

Please complete and return by fax prior to sending a worker to a Clinical Location for testing.
This Notification Form allows us to contact the Clinic if there is an issue with the drug and/or alcohol collection.

	PLEASE PRINT		**Clinic Used**
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	
Last Name	First Name	Employee ID#(Union Book #) Craft	

PLEASE FAX TO:
314-645-6767 or 866-645-6767

EXHIBIT E

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
REASONABLE SUSPICION/CAUSE DOCUMENTATION

Prepare this form every time an Employee is suspected of alcohol and / or drug use by actions, appearance or conduct which constitutes a major change in the person's appearance and / or behavior.

Employee Name: _____

Date of Observation: _____

Time of Observation: From: _____ AM or PM To:_____ AM or PM

Location _____

Observed behavior - circle all appropriate items:

SPEECH		BALANCE	WALKING
thick	incoherent	unsteady	stumbling
rapid	excessive	swaying	staggering
slurred		falling	grasping for support

EMOTIONAL INDICATORS		PHYSICAL INDICATORS	
depression	withdrawal	pupils dilated	cold sweats
anxiety	moodiness	redness of eyes	rapid breathing
alienation	irritability	weight loss	neglect of personal hygiene
		loss of appetite	odor of marijuana
		tremors	odor of an alcoholic beverage

Other abnormal behavior observed: _____

_____

To the best of my knowledge and belief, this report represents the appearance, behavior and / or conduct of the above named employee, observed by me and upon which I base my decision to request said employee to submit to reasonable suspicion/cause drug and alcohol testing.

Above behavior witnessed by:

_____ _____
Signature of Company Official Signature of witness

_____ _____
Date Date

Please Fax To:
314-645-6767 or 866-645-6767

EXHIBIT F

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING. SAFETY & MEDICAL MANAGEMENT COMPANY

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
REINSTATEMENT REQUIREMENTS

As a result of your confirmed positive drug or alcohol test, you have been placed in the Inactive Suspended Pool. While you are in this pool you are disqualified from employment with the Company until the following conditions have been met:

A. Completion of a Substance Abuse Assessment, Rehabilitation and/or Treatment Program

1. You should contact your Medical Provider immediately to begin this process because:

   a. Your failure to promptly seek and enroll within a reasonable period of time (not to exceed six (6) months from the time in which you were first taken off the job site) in a substance abuse assessment, rehabilitation or treatment program, or

   b. Your failure to participate in an approved assistance program, or

   c. Your abandonment of a treatment program prior to completion and/or being properly released will disqualify you from employment with the Company.

2. You must provide evidence to CDS of your completion, or release from an approved substance abuse counseling assessment, rehabilitation or treatment program prior to taking your return-to-work drug test.

B. A Negative Return to Work Drug and Alcohol Test

Upon the completion of your substance abuse assessment, rehabilitation or treatment program and completion of consequences for violation of the Substance Abuse Testing and Treatment Program Policy, you will be required to successfully pass a return-to-work drug and alcohol test. This test must be conducted at a site approved by CDS. For further assistance, contact CDS at 1-800-439-1454.

C. Completion of Consequences for Violation of the Substance Abuse Testing Policy

Refer to the Substance Abuse Testing and Treatment Program Policy for Consequences of Violation.

D. Probationary Status

If you elected to participate in an Assessment, Rehabilitation and/or Treatment Program and have provided a negative return to work drug and alcohol test, you can be returned to the Active Pool and be eligible for employment with the Company under a probationary status. Employees being returned to the Active Pool will be subject to SIX (6) intermittent drug and alcohol tests during the first year of your return to the Active Pool.

Employee signature	Union Book Number	Date

Employee PRINTED name	Employer

Witnessed by	Date

Please fax completed form to: 314-645-6767 or 866-645-6767

EXHIBIT G

Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT

SHEET METAL WORKERS LOCAL UNION #33
SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM POLICY
CHECK POOL STATUS

Employer: _____ By: _____ Date:_____

Access #: _____ Password:_____

RETURN FAX # _____

PLEASE PRINT

Last Name	First Name	Employee ID# (Union Book #)	ACTIVE	INACTIVE	RANDOM	PENDING	REINSTATE

Please fax completed form to: 314-645-6767 or 866-645-6767